

BEISCHEL FAMILY DENTAL

7125 E. Lincoln Drive, Suite B-108
Paradise Valley, AZ 85253
480.948.1450

In Event of an Emergency:

Who should we contact? _____

Relation: _____

Home Phone #: _____

Work or Cell #: _____

M.D. Name: _____

M.D. Phone #: _____

List Medical Specialists you see: _____

Phone #'s: _____

Nearest Friend or Relative not living with you:

Name: _____

Phone #: _____

Today's Date: _____

Patient Name: _____
Last First MI

What You Prefer To Be Called: _____ M F

Birthdate: ____/____/____ Age: ____ SS#: _____

Mailing Address: _____

Home Phone #: _____

Work Phone #: _____

Cell Phone #: _____

E-mail Address: _____

Employer: _____

Employer's Address: _____

Occupation: _____

Status: Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How Many? _____

Person ultimately responsible for account:

Name: _____

Relation: _____

Address: _____

SS #: _____

Driver's License #: _____

State: _____ Expiration: _____

Work Phone #: _____

Payment Method: Cash Check

_____/____/____

Credit Card – enter card # above (if accepted) CCV _____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any and all balances not paid by my insurance company within 45 days.

_____ Initials

Primary Dental Insurance (if any)

Co. Name: _____

Address: _____

Phone #: _____ ID #: _____

Insured's Name: _____ Relation: _____

Date of Birth: ____/____/____ SS#: _____

Insured's Employer: _____

Secondary Dental Insurance (if any)

Co. Name: _____

Address: _____

Phone #: _____ Group #: _____

Insured's Name: _____ Relation: _____

Date of Birth: ____/____/____ SS#: _____

Insured's Employer: _____

OVER 

Do you have or have you ever had any of the following diseases, medical conditions or procedures?

- Y N AIDS/ARC Aids Related Complex
Positive HIV Blood Test
When? _____
- Y N Allergy to Anesthetics
What? _____
- Y N Allergy to Latex Rubber
Reaction? _____
- Y N Anemia
Any Bleeding/Clotting or Other Blood Disorders _____
- Y N Any Allergies (Note Below)
- Y N Anorexia/Bulimia/Any Eating Disorder
What? _____
- Y N Arthritis/Rheumatism
- Y N Asthma
- Y N Back Problems
What? _____
- Y N Blood Transfusion
When? _____
- Y N Cancer/Tumors
Diagnosed _____
Radiation or Chemotherapy?
When? _____
- Y N Chemical/Alcohol Dependency
What? _____
Consumed/Week _____
- Y N Circulatory Problems
- Y N Cosmetic Surgery: _____
- Y N Wear Contact Lenses
- Y N Emphysema
- Y N Depression; treatment; _____
- Y N Diabetes
- Y N Difficulty Breathing/Respiratory Problems
- Y N Epilepsy/Seizures
- Y N Fainting
- Y N Frequent Fever
- Y N Frequent Neck Pain
- Y N Glaucoma
- Y N Hay Fever
- Y N Headaches; Frequency: _____
Severity: _____
- Y N Hearing Loss/Aids
- Y N Heart Problems of Any Type
- Y N Heart Attack/Stroke; when _____
- Y N Heart Surgery; when _____
- Y N Heart Murmur; diagnosed: _____
- Y N Rheumatic Fever, Scarlet Fever or Congenital Heart Defect
- Y N Angina/Chest Pains
- Y N Artificial Heart Valve
- Y N Mitral Valve Prolapse/Floppy Valve
- Y N Pacemaker; placed: _____
- Y N High Blood Pressure
- Y N Low Blood Pressure
- Y N Hepatitis
- Y N Hypoglycemia
- Y N Implants of Any Type
Artificial Joints/Bones: _____
- Y N Jaw Problems – TMD/TMJ
Left Right Both (circle one)
- Y N Kidney Disease
- Y N Liver Disease
- Y N Nervous Problems
- Y N Night Sweats
- Y N Recreational Drug Use; what: _____
- Y N Shingles
- Y N Sinus Problems
- Y N Swollen Lymph Nodes
Location: _____
- Y N Thyroid Condition
- Y N Tuberculosis/TB
- Y N Ulcer/Stomach Problems
- Y N Unexplained Weight Loss

Reason for today's visit: Exam Emergency Consultation
Are you in pain? Yes No How long? _____

Please indicate any of the following problems:
 Discomfort, Clicking, Popping or Locking Jaw Lost/Broken Filling(s) Stained Teeth
 Red, Swollen or Bleeding Gums Teeth Grinding/Clenching Bad Breath
 Sensitive Tooth, Teeth, Gums or Jaw Ringing in Ears Other: _____
 Blisters/Sores in or Around the Mouth Broken/Chipped Teeth _____
 Food Catching Between Teeth Swelling or Sore(s) in Mouth _____

Do you require pre-medication? Yes No Don't Know

Previous Dentist: _____ Phone #: _____
 Last Dental Exam: _____ Last Dental X-Rays: _____
 How often do you brush? _____ How often do you floss? _____
 What type of toothbrush do you use? Manual (what kind) _____ Electric (what kind) _____

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Are you satisfied with your smile? Yes No
 Do you have any dental anxiety? (None) 1 2 3 4 5 6 7 8 9 10 (High)
 Have you ever had your teeth straightened? Yes No
 Have you had any unfavorable reaction associated with dental treatment? Yes No
 If yes, please explain: _____

Have you been satisfied with your previous dental care? Yes No
 If no, please explain: _____

Would you like to keep your natural teeth? Yes No
 Have you ever been treated for Periodontal Disease (Gum Disease)? Yes No
 Has anyone in your family ever been treated for Periodontal Disease? Yes No
 Do you have any removable partials or dentures? Yes No

Please list all medications you take (prescription and over the counter, including vitamins, herbals & supplements):

Are you taking any of the following medications?
 Nerve Pills Pain Killers (including aspirin) Muscle Relaxers Stimulants
 Blood Thinners Tranquilizers Insulin Other(s): _____

Please list any other medical condition(s) you have or ever had:

Are you allergic to any of the following?
 Latex Penicillin/Amoxicillin Tetracycline Aspirin Dental Anesthetics
 Others: _____
 Do you use tobacco? No Yes – How Used? _____ How Much? _____ How Long? _____
 Please rate your general health from 1-10: _____
 Have you ever taken the drug Phen-fen and/or Redux? Yes No
For Women: Are you taking birth control pills? No Yes
 * Antibiotics can make the pill ineffective for one month past month(s) of ingestion *
 Are you pregnant? No Yes/How Long? _____ Are you nursing? No Yes

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient. Our policy requires that payment in full for all services rendered at the time of visit. If account is not paid in full within 45 days of the date of service, regardless of insurance status, you will be responsible for interest charges, collection agency fees and any other expenses or legal fees incurred in collecting your account.

- I give authorization to the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or to aid in my treatment at any dental specialist to which I or the patient is referred.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand that it is my responsibility to inform this office of any changes to the information that I have provided.
- I give my permission to have my health discussed with my medical doctors of record that I have noted on this form.
- I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. Details available at the front desk.

Signature: _____ Date: _____

Adult Patient Parent or Guardian (print name) _____